Complete Summary

GUIDELINE TITLE

Screening and treatment for major depressive disorder in children and adolescents: U.S. Preventive Services Task Force recommendation statement.

BIBLIOGRAPHIC SOURCE(S)

US Preventive Services Task Force. Screening and treatment for major depressive disorder in children and adolescents: US Preventive Services Task Force recommendation statement. Pediatrics 2009 Apr;123(4):1223-8. PubMed

GUIDELINE STATUS

This is the current release of the guideline.

This release updates a previously published guideline: U.S. Preventive Services Task Force. Screening for depression: recommendations and rationale. Ann Intern Med 2002 May 21;136(10):760-4. [13 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Major depressive disorder (MDD)

Note: This report focuses only on screening for MDD, and does not address screening for various less severe depressive disorders.

GUIDELINE CATEGORY

Prevention
Screening

CLINICAL SPECIALTY

Family Practice
Pediatrics
Preventive Medicine
Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians

GUIDELINE OBJECTIVE(S)

- To update the 2002 U.S. Preventive Services Task Force (USPSTF) recommendation on screening for child and adolescent major depressive disorder (MDD)
- To summarize the current USPSTF recommendations and supporting scientific evidence on screening for child and adolescent MDD

TARGET POPULATION

Adolescents (12 to 18 years of age) and children (7 to 11 years of age) in the general population

INTERVENTIONS AND PRACTICES CONSIDERED

Screening for major depressive disorder (MDD) using the Patient Health Questionnaire for Adolescents (PHQ-A) or the Beck Depression Inventory—Primary Care Version (BDI-PC)

MAJOR OUTCOMES CONSIDERED

Key Question 1: Does screening for depression among children and adolescents in the primary care setting improve health outcomes?

Key Question 1a: Does screening increase the proportion of patients identified with and/or treated for depression?

Key Question 2: Are depression screening instruments for children and adolescents accurate in identifying depression in primary care or school-based clinics?

Key Question 3: What are the harms of screening?

Key Question 4: Does treatment of depression (selective serotonin reuptake inhibitors [SSRIs] and/or psychotherapy) among screen-detected children and adolescents identified in primary care or comparable populations improve health outcomes?

Key Question 5: What are the adverse effects of treatment?

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases
Searches of Unpublished Data

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Oregon Evidence-based Practice Center (EPC) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

Using the methods of the USPSTF (detailed in Appendix B of the Evidence Review [see the "Availability of Companion Documents" field), EPC staff developed an analytic framework (Figure 1 of the Evidence Review [see the "Availability of Companion Documents" field]) and five key questions (KQ) to guide the literature search. KQ1 assessed direct evidence that screening programs for depression among average-risk child and adolescent primary care patients reduce morbidity and/or mortality. KQ1a examined whether screening increases the proportion of patients identified with and/or treated for depression. KQ2 addressed the accuracy of depression screening instruments for children and adolescents in identifying depression in primary care or school-based clinics. KQ3 examined the harms of screening for depression in children and adolescents. KQ4 addressed the effectiveness of treating screen-detected children and adolescents with selective serotonin reuptake inhibitors (SSRIs) and/or psychotherapy. KQ5 assessed serious adverse effects of SSRI and/or psychotherapy treatments for depression in children and adolescents. In conjunction with members of the USPSTF, EPC staff restricted the scope of this report to include only SSRIs. Fluoxetine is currently the only agent U.S. Food and Drug Administration (FDA)-approved to treat pediatric depression. The scope was broadened to include all SSRIs because they act through a similar mechanism to fluoxetine and are most commonly prescribed. Tricyclic antidepressants were demonstrated to lack efficacy in previous evidence reviews and newer atypical antidepressants are not approved for treating depression among youth.

For all key questions, EPC staff searched for systematic reviews, meta-analyses, and evidence-based guidelines on depression screening, treatment, or associated harms in children and adolescents in the Database of Abstracts of Reviews of

Effects (DARE), the Cochrane Database of Systematic Reviews (CDSR), MEDLINE, and PsycINFO from 1998 through May 2006. EPC staff also conducted a series of searches for each key question and reviewed the search results for applicability to all key questions. For KQs 1-3, addressing screening outcomes, accuracy, and harms, EPC staff searched for depression screening in children and adolescents in primary care to cover the time period since the previous USPSTF review (1998 through May 2007) in MEDLINE, PsycINFO, and the Cochrane Collaboration Registry of Clinical Trials (CCRCT) without restrictions on study designs. For KQ4, EPC staff searched for randomized controlled trials/controlled clinical trials (RCTs/CCTs) of psychotherapy and SSRI treatment in children and adolescents in MEDLINE, PsycINFO, and CCRCT in two separate searches covering 1998 through May 2007 for psychotherapy and 2004 through May 2007 for SSRIs. For KQ5, EPC staff searched for adverse effects of SSRIs and psychotherapeutic treatment, without restrictions on study designs, in two separate searches covering 1990 through May 2007 for psychotherapy and 2004 through May 2007 for SSRIs. The search period for SSRI treatment trials (safety and efficacy) began in 2004 because several previous systematic reviews provided good coverage through 2004. The search period for adverse effects of psychotherapy began in 1990 because harms of treatment were not addressed in the previous USPSTF review. Articles were also obtained from outside experts and through reviewing bibliographies of other relevant articles and systematic reviews. In addition to these searches for published trials, pharmaceutical company and federal agency trial registries were searched for unpublished trials of SSRIs. All searches were limited to articles in English. Inclusion and exclusion criteria specific to each question are detailed in Appendix B of the Evidence Review (see the "Availability of Companion Documents" field).

NUMBER OF SOURCE DOCUMENTS

The Evidence-based Practice Center (EPC) staff reviewed a total of 5,737 abstracts and 480 complete articles for all key questions (see Appendix B, Figure B1 of the Evidence Review [see the "Availability of Companion Documents" field]).

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Oregon Evidence-based Practice Center

(EPC) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

Two investigators independently reviewed all abstracts for Key Questions (KQs) 4 and 5. The initial search for KQs 1-3 produced a very high yield (3,418 abstracts). Therefore, EPC staff used a modified approach to reviewing these abstracts, detailed in Appendix B of the Evidence Review (see the "Availability of Companion Documents" field). Two investigators evaluated abstracts against a set of inclusion/exclusion criteria, including independent review using design-specific quality criteria based on the USPSTF methods, supplemented by National Institute for Health and Clinical Excellence (NICE) criteria for quality of systematic reviews (Appendix B, Table B3 of the Evidence Review [see the "Availability of Companion Documents" field]). Two investigators critically appraised all studies excluded for quality reasons. Data from included studies were abstracted into evidence tables by one investigator and checked by a second. No data were found for KQs 1, 1a, and 3. Data synthesis for KQ2, psychotherapy (KQ4 & 5), combined psychotherapy and selective serotonin reuptake inhibitors (SSRI) interventions (KQ4 and 5), and observational data on harms of SSRIs (KQ5) were qualitative because heterogeneity in the interventions, samples, and settings did not allow for quantitative synthesis. For evidence on the efficacy and adverse effects of SSRIs, EPC staff calculated pooled absolute risk differences using random effects models and narratively described data from other meta-analyses. Details of the quantitative synthesis approach and rationale are described in detail in Appendix B of the Evidence Review "see the Availability of Companion Documents" field).

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) systematically reviews the evidence concerning both the benefits and harms of widespread implementation of a preventive service. It then assesses the certainty of the evidence and the magnitude of the benefits and harms. On the basis of this assessment, the USPSTF assigns a letter grade to each preventive service signifying its recommendation about provision of the service (see Table below). An important, but often challenging, step is determining the balance between benefits and harms to estimate "net benefit" (that is, benefits minus harms).

Table 1. U.S. Preventive Services Task Force Recommendation Grid*

Certainty of Net Benefit	Magnitude of Net Benefit			
	Substantial	Moderate	Small	Zero/Negative
High	A	B	C	D
Moderate	B	B	C	D
Low	Insufficient			

**A*, *B*, *C*, *D*, and *I (Insufficient)* represent the letter grades of recommendation or statement of insufficient evidence assigned by the U.S. Preventive Services Task Force after assessing certainty and magnitude of net benefit of the service (see the "Rating Scheme for the Strength of the Recommendations" field).

The overarching question that the Task Force seeks to answer for every preventive service is whether evidence suggests that provision of the service would improve health outcomes if implemented in a general primary care population. For screening topics, this standard could be met by a large randomized, controlled trial (RCT) in a representative asymptomatic population with follow-up of all members of both the group "invited for screening" and the group "not invited for screening."

Direct RCT evidence about screening is often unavailable, so the Task Force considers indirect evidence. To guide its selection of indirect evidence, the Task Force constructs a "chain of evidence" within an analytic framework. For each key question, the body of pertinent literature is critically appraised, focusing on the following 6 questions:

1. Do the studies have the appropriate research design to answer the key question(s)?
2. To what extent are the existing studies of high quality? (i.e., what is the internal validity?)
3. To what extent are the results of the studies generalizable to the general U.S. primary care population and situation? (i.e., what is the external validity?)
4. How many studies have been conducted that address the key question(s)? How large are the studies? (i.e., what is the precision of the evidence?)
5. How consistent are the results of the studies?
6. Are there additional factors that assist us in drawing conclusions (e.g., presence or absence of dose–response effects, fit within a biologic model)?

The next step in the Task Force process is to use the evidence from the key questions to assess whether there would be net benefit if the service were implemented. In 2001, the USPSTF published an article that documented its systematic processes of evidence evaluation and recommendation development. At that time, the Task Force's overall assessment of evidence was described as good, fair, or poor. The Task Force realized that this rating seemed to apply only to how well studies were conducted and did not fully capture all of the issues that go into an overall assessment of the evidence about net benefit. To avoid confusion, the USPSTF has changed its terminology. Whereas individual study quality will continue to be characterized as good, fair, or poor, the term *certainty* will now be used to describe the Task Force's assessment of the overall body of evidence about net benefit of a preventive service and the likelihood that the assessment is correct. Certainty will be determined by considering all 6 questions listed above; the judgment about certainty will be described as high, moderate, or low.

In making its assessment of certainty about net benefit, the evaluation of the evidence from each key question plays a primary role. It is important to note that the Task Force makes recommendations for real-world medical practice in the United States and must determine to what extent the evidence for each key question—even evidence from screening RCTs or treatment RCTs—can be applied to the general primary care population. Frequently, studies are conducted in

highly selected populations under special conditions. The Task Force must consider differences between the general primary care population and the populations studied in RCTs and make judgments about the likelihood of observing the same effect in actual practice.

It is also important to note that 1 of the key questions in the analytic framework refers to the potential harms of the preventive service. The Task Force considers the evidence about the benefits and harms of preventive services separately and equally. Data about harms are often obtained from observational studies because harms observed in RCTs may not be representative of those found in usual practice and because some harms are not completely measured and reported in RCTs.

Putting the body of evidence for all key questions together as a chain, the Task Force assesses the certainty of net benefit of a preventive service by asking the 6 major questions listed above. The Task Force would rate a body of convincing evidence about the benefits of a service that, for example, derives from several RCTs of screening in which the estimate of benefits can be generalized to the general primary care population as "high" certainty (see the "Rating Scheme for the Strength of Recommendations" field). The Task Force would rate a body of evidence that was not clearly applicable to general practice or has other defects in quality, research design, or consistency of studies as "moderate" certainty. Certainty is "low" when, for example, there are gaps in the evidence linking parts of the analytic framework, when evidence to determine the harms of treatment is unavailable, or when evidence about the benefits of treatment is insufficient. Table 4 in the methodology document listed below (see "Availability of Companion Documents" field) summarizes the current terminology used by the Task Force to describe the critical assessment of evidence at all 3 levels: individual studies, key questions, and overall certainty of net benefit of the preventive service.

Sawaya GF, et al. Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. Ann Intern Med. 2007;147:871-875 [5 references].

For I statements, the USPSTF has a new plan to commission its Evidence-based Practice Centers to collect information in 4 domains pertinent to clinical decisions about prevention and to report this information routinely. This plan is described in a paper that was published with the Skin Cancer recommendation: Petitti DB et al. Update on the methods of the U.S. Preventive Services Task Force: insufficient evidence. Ann Intern Med. 2009;150:199-205 (see "Availability of Companion Documents" field).

The first domain is potential preventable burden of suffering from the condition. When evidence is insufficient, provision of an intervention designed to prevent a serious condition (such as dementia) might be viewed more favorably than provision of a service designed to prevent a condition that does not cause as much suffering (such as rash). The USPSTF recognized that "burden of suffering" is subjective and involves judgment. In clinical settings, it should be informed by patient values and concerns.

The second domain is potential harm of the intervention. When evidence is insufficient, an intervention with a large potential for harm (such as major

surgery) might be viewed less favorably than an intervention with a small potential for harm (such as advice to watch less television). The USPSTF again acknowledges the subjective nature and the difficulty of assessing potential harms: For example, how bad is a "mild" stroke?

The third domain is cost-not just monetary cost, but opportunity cost, in particular the amount of time a provider spends to provide the service, the amount of time the patient spends to partake of it, and the benefits that might derive from alternative uses of the time or money for patients, clinicians, or systems. Consideration of clinician time is especially important for preventive services with only insufficient evidence because providing them could "crowd out" provision of preventive services with proven value, services for conditions that require immediate action, or services more desired by the patient. For example, a decision to routinely inspect the skin could take up the time available to discuss smoking cessation, or to address an acute problem or a minor injury that the patient considers important.

The fourth domain is current practice. This domain was chosen because it is important to clinicians for at least 2 reasons. Clinicians justifiably fear that not doing something that is done on a widespread basis in the community may lead to litigation. More important, addressing patient expectations is a crucial part of the clinician-patient relationship in terms of building trust and developing a collaborative therapeutic relationship. The consequences of not providing a service that is neither widely available nor widely used are less serious than not providing a service accepted by the medical profession and thus expected by patients. Furthermore, ingrained care practices are difficult to change, and efforts should preferentially be directed to changing those practices for which the evidence to support change is compelling.

Although the reviewers did not explicitly recognize it when these domains were chosen, the domains all involve consideration of the potential consequences-for patients, clinicians, and systems-of providing or not providing a service. Others writing about medical decision making in the face of uncertainty have suggested that the consequences of action or inaction should play a prominent role in decisions.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

What the United States Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

Grade	Grade Definitions	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends against	Offer or provide this service only if

Grade	Grade Definitions	Suggestions for Practice
	routinely providing the service. There may be considerations that support providing the service in an individual patient. There is moderate or high certainty that the net benefit is small.	there are other considerations in support of the offering/providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality or conflicting, and the balance of benefits and harms cannot be determined.	Read "Clinical Considerations" section of USPSTF Recommendation Statement (see "Major Recommendations" field). If offered, patients should understand the uncertainty about the balance of benefits and harms.

USPSTF Levels of Certainty Regarding Net Benefit

Definition: The U.S. Preventive Services Task Force defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.

Level of Certainty	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as: • The number, size, or quality of individual studies • Inconsistency of findings across individual studies • Limited generalizability of findings to routine primary care practice • Lack of coherence in the chain of evidence As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health

Level of Certainty	Description
	outcomes. Evidence is insufficient because of: • The limited number or size of studies • Important flaws in study design or methods • Inconsistency of findings across individual studies • Gaps in the chain of evidence • Findings not generalizable to routine primary care practice • A lack of information on important health outcomes More information may allow an estimation of effects on health outcomes.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Peer Review. Before the U.S. Preventive Services Task Force makes its final determinations about recommendations on a given preventive service, the Evidence-Based Practice Center and the Agency for Healthcare Research and Quality send a draft evidence review to 4 to 6 external experts and to federal agencies and professional and disease-based health organizations with interests in the topic. They ask the experts to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the Task Force in memo form. In this way, the Task Force can consider these external comments before it votes on its recommendations about the service. Draft recommendation statements are then circulated for comment from reviewers representing professional societies, voluntary organizations and Federal agencies. These comments are discussed before the final recommendations are confirmed.

Comparison with Guidelines from Other Groups. Recommendations for screening from the following groups were discussed: Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, the American Academy of Pediatrics (AAP), the American Medical Association (AMA), the Canadian Task Force on Preventive Health Care (CTFPHC), and the Society for Adolescent Medicine.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The US Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and identifies the Levels of Certainty regarding Net Benefit (High, Moderate, and Low). The definitions of these grades can be found at the end of the "Major Recommendations" field.

Summary of Recommendations and Evidence

The USPSTF recommends screening of adolescents (12 to 18 years of age) for major depressive disorder (MDD) when systems are in place to assure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up. **This is a B recommendation**.

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening of children (7 to 11 years of age) for MDD. **This is an I statement**.

Clinical Considerations

Patient Population under Consideration

This USPSTF recommendation addresses screening for MDD in adolescents (12 to 18 years of age) and in children (7 to 11 years of age) in the general population. There is a spectrum of depressive disorders. This report focuses only on screening for MDD, and does not address screening for various less severe depressive disorders.

Assessment of Risk

A variety of factors contribute to the development of MDD. Most people who develop MDD have multiple risk factors. However, risk factors for MDD can be difficult to assess. As a result, researchers have focused on identifying youth subgroups at increased risk of developing MDD. Important risk factors that can be assessed relatively accurately and reliably include parental depression, having comorbid mental health or chronic medical conditions, and having experienced a major negative life event.

Screening Tests

Instruments developed for primary care (Patient Health Questionnaire for Adolescents [PHQ-A] and the Beck Depression Inventory−Primary Care Version [BDI-PC]) have been used successfully in adolescents. There are limited data describing the accuracy of using MDD screening instruments in younger children (7 to 11 years of age).

Treatment

Among pharmacotherapies available for the treatment of MDD in children and adolescents, selective serotonin reuptake inhibitors (SSRIs) have been found to be efficacious. Treating depressed youth with SSRIs is associated with an increased risk of suicidality, and therefore should only be considered if judicious clinical monitoring is possible. Psychotherapy trials indicate that a variety of psychotherapy types are efficacious among adolescents (including cognitive-behavioral and interpersonal therapies). Harms of psychotherapy are felt to be small.

Definitions:

What the United States Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

Grade	Grade Definitions	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is moderate or high certainty that the net benefit is small.	Offer or provide this service only if there are other considerations in support of the offering/providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality or conflicting, and the balance of benefits and harms cannot be determined.	Read "Clinical Considerations" section of USPSTF Recommendation Statement (see "Major Recommendations" field). If offered, patients should understand the uncertainty about the balance of benefits and harms.

USPSTF Levels of Certainty Regarding Net Benefit

Definition: The U.S. Preventive Services Task Force defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF

assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.

Level of Certainty	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as: • The number, size, or quality of individual studies • Inconsistency of findings across individual studies • Limited generalizability of findings to routine primary care practice • Lack of coherence in the chain of evidence As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: • The limited number or size of studies • Important flaws in study design or methods • Inconsistency of findings across individual studies • Gaps in the chain of evidence • Findings not generalizable to routine primary care practice • A lack of information on important health outcomes More information may allow an estimation of effects on health outcomes.

CLINICAL ALGORITHM(S)

None available

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Benefits of Detection and Early Intervention

- Adolescents (12 to 18 years of age). The U.S. Preventive Services Task Force (USPSTF) found adequate evidence that treatment in adolescents with selective serotonin reuptake inhibitors (SSRIs), psychotherapy, and with combined therapy (SSRIs and psychotherapy) results in decreases in major depressive disorder (MDD) symptoms.
- Children (7 to 11 years of age). The USPSTF found inadequate evidence to support the benefits of treatment in children. SSRIs (fluoxetine) reduce MDD symptoms in children; however, there are limited data on the benefits of psychotherapy and the benefits of psychotherapy plus SSRIs in children.

POTENTIAL HARMS

Harms of Detection and Early Treatment

- Adolescents (12 to 18 years of age): There is convincing evidence that there are harms of selective serotonin reuptake inhibitors (SSRIs) (risk of suicidality, [i.e., suicide ideation, preparatory acts, or suicide attempts]) in adolescents. Limited evidence exists regarding the harms of combining SSRIs and psychotherapy. However, there is inadequate evidence about the harms of screening and psychotherapy in adolescents, which are probably small.
- Children (7 to 11 years of age): SSRIs (fluoxetine) demonstrated harms in children (risk of suicidality); however, there is limited evidence on the harms of psychotherapy and on the harms of combining psychotherapy and SSRIs (fluoxetine) in children. There is also limited evidence about the harms of screening children. The USPSTF judged that the overall evidence is inadequate regarding the harms of screening and treatment in children.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The U.S. Preventive Services Task Force (USPSTF) makes recommendations about preventive care services for patients without recognized signs or symptoms of the target condition.
- Recommendations are based on a systematic review of the evidence of the benefits and harms and an assessment of the net benefit of the service.
- The USPSTF recognizes that clinical or policy decisions involve more considerations than this body of evidence alone. Clinicians and policy-makers should understand the evidence but individualize decision making to the specific patient or situation.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical

recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the Agency for Healthcare Research and Quality will make all U.S. Preventive Services Task Force (USPSTF) products available through its Web site. The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access U.S. Preventive Services Task Force materials and adapt them for their local needs. Online access to U.S. Preventive Services Task Force products also opens up new possibilities for the appearance of the annual, pocket-size *Guide to Clinical Preventive Services*.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals, and test results are not always centralized.

IMPLEMENTATION TOOLS

Foreign Language Translations
Patient Resources
Personal Digital Assistant (PDA) Downloads
Pocket Guide/Reference Cards

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

US Preventive Services Task Force. Screening and treatment for major depressive disorder in children and adolescents: US Preventive Services Task Force recommendation statement. Pediatrics 2009 Apr;123(4):1223-8. PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1996 (revised 2009 Apr)

GUIDELINE DEVELOPER(S)

United States Preventive Services Task Force - Independent Expert Panel

GUIDELINE DEVELOPER COMMENT

The U.S. Preventive Services Task Force (USPSTF) is a federally-appointed panel of independent experts. Conclusions of the U.S. Preventive Services Task Force do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or its agencies.

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Task Force Members: Ned Calonge, MD, MPH, *Chair*, USPSTF (Colorado Department of Public Health and Environment, Denver, CO); Diana B. Petitti, MD, MPH , *Vice-chair*, USPSTF (Arizona State University, Phoenix, AZ);Thomas G. DeWitt, MD Children's Hospital Medical Center, Cincinnati, OH); Allen Dietrich, MD, (Dartmouth Medical School, Lebanon, NH); Leon Gordis, MD, MPH, DrPH (Johns Hopkins Bloomberg School of Public Health, Baltimore, MD); Kimberly D. Gregory, MD, MPH (Cedars-Sinai Medical Center, Los Angeles, CA); Russell Harris, MD, MPH (University of North Carolina School of Medicine, Chapel Hill, NC); George Isham, MD, MS, (HealthPartners, Minneapolis, MN); Michael L. LeFevre, MD, MSPH (University of Missouri School of Medicine, Columbia, MO); Rosanne Leipzig, MD, PhD (Mount Sinai School of Medicine, New York, NY); Carol Loveland-Cherry, PhD, RN (University of Michigan School of Nursing, Ann Arbor, MI); Lucy N. Marion, PhD, RN (School of Nursing, Medical College of Georgia, Augusta, GA); Virginia A. Moyer, MD, MPH (Baylor College of Medicine, Houston, TX); Judith K. Ockene, PhD (University of Massachusetts Medical School, Worcester, MA); George F. Sawaya, MD (University of California, San Francisco, CA); and Barbara P. Yawn, MD, MSc (Olmsted Medical Center, Rochester, MN)

**Members of the Task Force at the time this recommendation was finalized. For a list of current Task Force members, go to www.ahrq.gov/clinic/uspstfab.htm.*

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The U.S. Preventive Services Task Force has an explicit policy concerning conflict of interest. All members disclose at each meeting if they have a significant financial, professional/business, or intellectual conflict for each topic being discussed. Task Force members with conflicts may be recused from discussing or voting on recommendations about the topic in question.

GUIDELINE STATUS

This is the current release of the guideline.

This release updates a previously published guideline: U.S. Preventive Services Task Force. Screening for depression: recommendations and rationale. Ann Intern Med 2002 May 21;136(10):760-4. [13 references]

GUIDELINE AVAILABILITY

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site and the Pediatrics Web site.

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Evidence Review:

- Williams SB, O'Connor, E, Eder M, Whitlock E. Screening for child and adolescent depression in primary care settings: a systematic evidence review for the U.S. Preventive Services Task Force. Evidence Synthesis No. 69. AHRQ Publication No. 09-05130-EF-1. Rockville, Maryland: Agency for Healthcare Research and Quality, 2009 Apr. 71 p. Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site.
- Williams SB, O'Connor, E, Eder M, Whitlock E. Screening for child and adolescent depression in primary care settings: a systematic evidence review for the U.S. Preventive Services Task Force. Review article. Pediatrics 2009;123(4):e716-e735. Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site and the Pediatrics Web site.

The following is also available:

- Screening and treatment for major depressive disorder in children and adolescents. Clinical summary of U.S. Preventive Services Task Force recommendation. 2009. 1 p.

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site.

Background Articles:

- Barton M et al. How to read the new recommendation statement: methods update from the U.S. Preventive Services Task Force. Ann Intern Med. 2007;147:123-127.
- Guirguis-Blake J et al. Current processes of the U.S. Preventive Services Task Force: refining evidence-based recommendation development. Ann Intern Med. 2007;147:117-122. [2 references]
- Sawaya GF et al., Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. Ann Intern Med. 2007;147:871-875. [5 references].
- Petitti DB, Teutsch SM, Barton MB, Sawaya GF, Ockene JK, DeWitt T. Update on the methods of the U.S. Preventive Services Task Force: insufficient evidence. Ann Intern Med. 2009;150:199-205.

Electronic copies: Available from U.S. Preventive Services Task Force (USPSTF) Web site.

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

The Electronic Preventive Services Selector (ePSS), available as a PDA application and a web-based tool, is a quick hands-on tool designed to help primary care clinicians identify the screening, counseling, and preventive medication services that are appropriate for their patients. It is based on current recommendations of the USPSTF and can be searched by specific patient characteristics such as age, sex, and selected behavioral risk factors.

PATIENT RESOURCES

The following are available:

- Men: stay healthy at any age. Your checklist for health. Rockville (MD): Agency for Healthcare Research and Quality. AHRQ Pub. No. 07-IP006-A. February 2007. Electronic copies: Available from the USPSTF Web site. See the related QualityTool summary on the Health Care Innovations Exchange Web site.
- Women: stay healthy at any age. Your checklist for health. Rockville (MD): Agency for Healthcare Research and Quality. AHRQ Pub. No. 07-IP005-A. February 2007. Electronic copies: Available from the USPSTF Web site. See the related QualityTool summary on the Health Care Innovations Exchange Web site.

Print copies: Available in English and Spanish from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

Myhealthfinder is a new tool that provides personalized recommendations for clinical preventive services specific to the user's age, gender, and pregnancy status. It features evidence-based recommendations from the USPSTF and is available at www.healthfinder.gov.

NGC STATUS

This summary was completed by ECRI on June 30, 1998. The information was verified by the guideline developer on December 1, 1998. This summary was updated by ECRI on May 7, 2002. The updated information was verified by the guideline developer as of May 14, 2002. This summary was updated by ECRI Institute on November 2, 2007, following the U.S. Food and Drug Administration advisory on Antidepressant drugs. This NGC summary was updated by ECRI Institute on March 30, 2009. The updated information was verified by the guideline developer on June 16, 2009.

COPYRIGHT STATEMENT

DISCLAIMER

NGC DISCLAIMER

The National Guideline Clearinghouse™ (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria which may be found at http://www.guideline.gov/about/inclusion.aspx .

NGC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI Institute, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.

Date Modified: 7/27/2009